COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE CHIEF DEPUTY DIRECTOR

AGENCY VERIFICATION OF HOMELESSNESS

CHECK THE APPROPRIATE BOXES UNDER HOMELESS OR CHRONICALLY HOMELESS

I certify that _____ is
(Name of Applicant)

❑ **HOMELESS**

- ❑ an individual who lacks a fixed, regular, and adequate nighttime residence (attach letter acknowledging current living situation along with homeless history with co-signature of program head, manager or director); or
- ❑ an individual who has a primary nighttime residence that is —
  - ❑ a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill) - (Complete and attach Certification of Residence in a Homeless Facility Form);
  - ❑ an institution that provides a temporary residence for individuals intended to be institutionalized -(Complete and attach Certification of Residence in a Homeless Facility Form); or
  - ❑ a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (attach letter acknowledging current living situation along with homeless history with co-signature of program head, manager or director).
- ❑ a victim of domestic violence who is unable to obtain housing - (attach letter explaining current circumstances with co-signature of program head, manager, or director).

OR

❑ **CHRONICALLY HOMELESS**

- ❑ homeless and lives in a place not meant for human habitation, a safe haven or in an emergency shelter, **and**
  - ❑ has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years (attach documentation of one (1) year of continuous homelessness or at least four (4) episodes of homelessness in the past three (3) years with co-signature of program head, manager or director); and
  - ❑ can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;
- ❑ an individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria as noted above of this definition, before entering that facility; or
- ❑ a family with an adult head of household (or if there is not adult in the family, a minor head of household) who meets all of the criteria as noted above of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Referring Agency Name: _____

Address: _____

Case Manager's Name/Signature _____

Date: _____ Telephone Number: _____

Program Head's Name/Signature: _____ Date: _____